VIII. Cost, Logistical, and Political Aspects of Intervention Programs; Resources; and Partnerships

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Before I prepared my slides, I tried to go through some questions related to program implementation. But I decided that if we go through them all, at the end we would say, "Let's go home. There is nothing we can do." So I thought we had better start with a few specific questions.

The basic questions are: Why are we here and where are we going with this program? What kind of programs do we need to go ahead with? What are the related issues that are beyond mother-to-child transmission? How much will the program cost? Who will put the money in it? And how are we going to implement it?

There are broad related issues such as poverty, development, discrimination and stigmatization, infrastructure strengthening, gender roles, culture, access to care, and orphans. All these issues are important and should be kept in mind. But we are not going to change them; if we attempt to change them completely before we start the program, we will never start. However, we need to move ahead with these issues in our mind.

With respect to costs, basically the cost issues are related to voluntary counseling and testing, and it obviously is more than just the cost of the test. WHO has a purchase system that provides HIV tests at very cheap prices through bulk purchase, so that is something that could be done about the cost of the test.

With respect to the cost of counseling, there also are some specific things such as group pre-test counseling that could be done to try to cut the cost as much as possible without compromising the quality of test.

For antiretrovirals, we have negotiated with the pharmaceutical companies, and the negotiations are ongoing. As most of you are aware, Glaxo Wellcome announced that they would reduce their prices by as much as 50 to 75 percent. But for countries with very poor resources, we would negotiate with them further to reduce costs even more.

Bulk purchase is also a very important option, especially in the countries where you have low prevalence rates and a low number of pregnant women. If we need to go for a package, we could have regional purchase systems that could help, decreasing not only the prices of the drugs but also the prices of handling and logistics.

Replacement feeding is important, with negotiation with the manufacturer or, as it was pointed out, preparation of generics, either locally or at the regional level.

Infant formula or infant-feeding counseling is also very, very important to consider. It adds a consistent amount of cost to any program we need to go ahead with. And it seems more and more likely that we should include multivitamins in the prenatal care package.

You will hear more about cost-effectiveness issues from Elliot Marseille. I am discussing this just to give you an example of the relative costs that were in the program and that should be considered in any program implementation.

For replacement feeding, there are some other parameters that should be kept in mind (although some countries may choose to implement them and others may implement only part of them): providing formula for 6 months, but also helping women to provide adequate feeding until 18 to 24 months through cow milk or through supplemental feed. One should keep in mind in any program that we need to budget for additional outpatient visits and additional costs for infant-feeding counseling.

Procurement and distribution are also important. When we want to go ahead with a program, we must determine whether we will go into a local procurement system, regional procurement system, or central procurement system. This decision has specific logistical implications that I will address later.

An important issue related to the differential distribution of antiretroviral treatment is that of the public health payer. If we decide that prevention of mother-to-child transmission is of public health relevance and that it should come from a public health budget, while it is not clear that other antiretroviral treatments should come from the public health budget, and if we procure from the same bulk antiretrovirals, it may become difficult logistically to distribute some of the AZT to pregnant women through public funds with other drug purchased by the patients themselves in the same hospital or the same pharmacy. So this issue must be kept in mind if we need to consider the public health payer. This may imply some special packaging.

Parallel distribution of replacement feeding is also very important. We mentioned that it could be prescribed medically. If we need to have tight control over the distribution of replacement feeds to avoid spillover, then this could be also linked to the distribution of antiretrovirals for a specific program.

And finally, and very, very important, is the stock control at the prenatal settings and at any distribution point. Although it seems to be just a detail, it accounts for many failures in the system.

So I come back to the packaging. The packaging also looks like something that is secondary, and sometimes it is stupid to think about it. But basically how many days of AZT are we going to put in the bottle if we are going to apply the Thai regimen? The median duration of treatment is 24 days, and this means half of women will use 24 days or less. But what about the others? Every single tablet has a cost, so how many are we going to put in the bottle? This is an example of a packaging problem.

The second example, which I pointed out, relates to whether we are going to use exactly the same package as for AZT treatment or are we going to package it differently? Presently we are in discussion with Glaxo Wellcome for a special package, since it is likely that the money will come from the public payer perspective.

Although not the case with the Thai regimens, for the other regimens, the bottles for

neonates are extremely cumbersome. The amount of AZT is 200 milliliters in the bottle, and 1 week's use of AZT in a neonate is less than 6 milliliters. This result in a lot of waste. These are big bottles and they are heavy, and we are working with Glaxo Wellcome on reducing the packaging.

Again, if we do special packaging for mother-to-child transmission, we also need to take into account adding multivitamins or whatever is needed with the prenatal package.

The same thing occurs for the replacement feeding. Do we need to purchase branded versus generic? And, if generic, how should this be done? The issue of discrimination is important, but here it could add another dimension if we know that the brown tin is given free to HIV-positive women, while the others are bought in the market. Thus, these also are considerations one has to keep in mind. It should be done strictly with respect for the marketing code.

Finally, in the infrastructure requirement, we need a well-established national policy. It is a prerequisite that includes the basic prenatal care, that is, the minimum requirements that are needed in the prenatal setting. We can go with the antiretroviral interventions in any setting, regardless of what is happening there. We do not need to strengthen them to a level that everything is available. So we must look at the minimum requirement and work toward that at least in some specific settings.

Regarding access to voluntary counseling and testing inside and outside prenatal settings, many workshop participants have pointed out that they need to focus not only on women, but also on their male partners. Social support is extremely important for the women to help them in facing these difficult issues, as is community involvement.

And finally, we need at this stage a clear surveillance system–we could call it operational research–to be able to monitor what we are doing, because we are not clear about the expected results.

I would like to add a word about communication. We need to develop clear and targeted communication strategies. If we want to avoid the discrimination related to program implementation, whether for replacement feeding or for antiretroviral administration, we need to make this issue popular and acceptable and increase the political will to address the problem. Communication has an important place in the program. We also need to involve the communities, the nongovernmental organizations, the charities, and people living with HIV.

Finally, and there have been many remarks about this, we need to educate the health workers, because in many settings the health workers are the first people to discriminate.

One word about the partnership: I think there is enough work for everybody, and we can take lessons from the work that has been done in the perinatal transmission field where people really have worked together for several years now. I see no reason why they cannot continue. One example of collaboration is UNAIDS which, together with WHO and UNICEF, has been working on developing the guidelines. UNICEF is taking the lead now in program implementation in 10 countries, with specific situation analyses. There are

various forms of working groups, and we need to rely on regional initiative.

In fact, the final message is to keep our thoughts simple and start implementation. There are very good people in the field who know what they are doing and who are able to adapt any plans to their local context. I think we are at the stage of going to implementation from thinking, so we should stop discussing and we should go to work now.